THE

CHICAGO MEDICAL JOURNAL.

Vol. XXV.—SEPTEMBER 1, 1868.—*No.* 17.

PATHOGENESIS.

The Pathological Anatomy and Pathogenesis of Disseminated Chronic Pneumonia, and of Pulmonary Tubercles. By H. LEBERT, *Professor of Clinical Medicine of the University of Breslau.*

TRANSLATED BY WALTER HAY, M.D., ASSOCIATE EDITOR CHICAGO MEDICAL JOURNAL.

IN the following pages I shall publish a few of my lessons upon chronic pneumonia and pulmonary tubercles. I should have attempted to give them entire, but that such a work would transcend the limits of an article for a periodical.

It is well known that for a long time the study of the diseases of the respiratory passages has possessed for me an especial attraction. Engaged for quite a long period in the experimental production of inflammatory and tubercular alterations in the lungs, I hope soon to be able to assemble all my experiments in a special work upon this important subject; but I desire at present to give a *resumé* of my anatomical and pathogenetic experiments upon this subject, seeing that, at this moment, it occupies the attention of pathological anatomists as well as of clinical observers, and indeed, that there is no subject of greater importance, since it concerns diseases

which harvest nearly a fifth part of the human race. The thorough investigation of the mode of existence, and of the formation of such maladies, must, sooner or later, result in effecting a diminution of the ravages of this terrible pestilence.

Before commencing the anatomical description, I should say that I avoid throughout this work, as much as possible, the term "phthisis pulmonalis," especially as it preceded the study of tubercle, and as it appears to have survived the unity of tuberculosis. It would indeed be convenient to understand by this term disseminated chronic pneumonia and pneumophymia (?), associated by a strong affinity, although all recent researches protest against their identity. Indeed, true tuberculosed subjects may succumb after an acute or subacute attack, with figures yet athletic, and with still a sub-cutaneous layer of fat. On the other hand, disseminated chronic pneumonia, in its mild and slightly febrile form, often permits its subjects, who have already cavities in their lungs, to occupy themselves with their business with a degree of vigor and a rotundity of figure far different from that of phthisis. Moreover, the patients who lose flesh and strength under, during the subacute exacerbations of disseminated pneumonia, recover them considerably, when the progress of the malady is retarded and the fever ceases, and the same subjects again emaciate when new foci of disease develop themselves. Thus a patient may be phthisical to-day, be so no longer in three months, and again be so in six; moreover, do not the subjects of chronic catarrh and bronchial dilatation become emaciated by a prolonged and considerable loss of albuminoid substance? Phthisis is, therefore, a morbid effect, and not a disease.

Another term, also very generally employed, and likewise entirely irrational, is that of the "caseous state." Nothing less resembles cheese, under its relations of structure, chemical composition and exterior aspect than the yellow infiltrations termed "caseous;" I am astonished that physicians, lovers of cheese, should not have long since protested against this term, which the lovers of correct and exact medical nomenclature ought very thoroughly to reprobate. To speak of an

infiltration as gray, yellow, circumscribed or diffuse, gives in truth a much clearer idea of the morbid tissue than to designate it as "cheesy." I avoid, with equal care also, the term scrofulous pneumonia. Scrofula, in the majority of cases, having nothing to do with pneumonia. The foci do not correspond with the limits of the lobules, their existence being just as probable in the interstitial and peribronchial connective tissue as in the alveoli. I prefer, likewise, the term disseminated pneumonia to that of lobular, or broncho-pneumonia.

The preliminary remarks concluded, we proceed to the anatomical descriptions.

I.—Pathological Anatomy.

We shall successively pass in review chronic disseminated pneumonia, originating from mechanical causes; then that developed spontaneously, and then true pulmonary tubercles.

We shall disregard chronic diffused and lobular pneumonia, which we have likewise observed and studied anatomically a sufficient number of times, and which is far from being so rare as some authors assert. However, its anatomical and clinical characteristics may associate it more closely with acute or subacute pneumonia, than with the little disseminated foci, or with tubercles, yet both these conditions may be found combined with diffuse infiltration.

1. *Chronic Disseminated Pneumonia from mechanical causes.*—The physicians who are engaged in the investigation of the subject of pulmonary tubercles, and of all relating to them, have very generally neglected the study of pulmonary inflammations from mechanical causes, because they believed them not to be correlated with tubercle. To-day, since the unity of chronic diseases of the lungs no longer exists, the majority of cases, considered formerly as tuberculous, but of slow progress, are shown to be, in reality, foci of inflammatory origin, the study of an intricate inflammatory process could not fail to be benefitted by comparison with similar foci, having an origin very well understood.

We have referred, in a preceding lecture, to the enormous mortality from maladies of the chest, observed by Peacock, of London, and Lewin, of Berlin, amongst the dressers of stone, especially of hard stones and mill stones. Lewin has recognized sharp and pointed bony particles in the expectoration of these laborers. Although anatomical investigations upon this subject are not numerous, yet Bristowe has discovered, from an observation of Peacock, in one of these lungs a very considerable quantity of cutting particles, sharp and transparent, of those collected in the workshop, composed of quartz and of silica.

We are in possession of very exact investigations of Zunker upon diseases of the lungs, caused by ferruginous particles. He has discovered *Oxyde of Iron* in all portions of the lungs, even in the pleura and bronchial glands, as also in the epithelial cells of the ultimate ramifications of the bronchial tubes, and of the air-cells. Many particles of iron having traversed the cellular parietes had reached the pulmonary tissue, especially in the lobular and fundibular partitions, as well as in the sheaths of the bronchial tubes, the sub-pleural tissue, and thence into the pleura, even traversing the lymphatic vessels. The iron had penetrated, not only into the bronchial glands, but also in those which are found by the side of the trachea. These serous (?) fragments had produced interstitial granulations, callous indurations corresponding to the lobules, like a pneumonia, disseminated, lobular, interstitial and peribronchial. There were, moreover, vomicæ, originating, probably, from bronchial ulcerations, and at the surface of the indurated portions of the partial pleuritic thickening.

Hence it appears that granules of iron, produce, eventually, in the lungs, all the manifestations, all the forms, all the phases of disseminated chronic pneumonia.

Coal-dust is less irritating to the lungs, and when it reaches them in small quantities, it appears even salutary in those occupations where it is used in moderate quantities. This is, however, not the case with workmen in mines of pit-coal, and there has been observed, during a long period, the state of

anæmia, and the impeded and prolonged respiration with which those who have labored for a long time in those mines are so frequently troubled whilst the lungs are healthy, and there is no chronic catarrrh, no trouble supervenes, and even in cases of bronchitis, the vibratile movements in the bronchial tubes for a long time prevents the particles of coal depositing themselves in the cells; a black expectoration accompanies the pulmonary catarrh of the laborer, and Traube has demonstrated that this dust has penetrated into the cellular elements of the expectoration.

But, at a later period these fragments of coal would reach the cells, pass through them, and forment at first, in the pulmonary parenchyma, little striated strains, which, at a later period become thicker, more compact, more confluent. It is only exceptionally that these masses attain to the size of a nut. They are found more frequently in the lower and middle lobes ahan in the upper. Masses are found also in some of the terminal bronchial ramifications, thence by degrees the bronchial glands become infiltrated. Whenever a chronic catarrh, with pulmonary emphysema is established, these alterations, at first very slow in developing themselves, are multiplied, and become more considerable. They terminate by constituting themselves true foci of disseminated chronic pneumonia, on this occasion not resembling the cheese of classic authors, but rather their fuel. These foci tend, at a later period, to a destructive process. It is thus that the carbonaceous cavities are formed, which, however, are far from being frequent, and rarely attain the dimensions of pneumonic cavities; their walls are irregular, sinuous, surrounded with a blackish compact tissue; they are met with as well in the inferior as in the superior lobes, in the centre as at the periphery. It is not unusual to find recent or old pleurisy, in its plastic pseudo-membranous form, originating from superficial carbonaceous foci. In rare cases there are found little abscesses in the vicinity of the indurations and the black cavities. It is only under exceptional circumstances that true tubercles are found in these lungs.

The more abundant the silica contained in this carbonaceous dust, the more rapid and invasive will be the progress of these alterations.

2. *Chronic Disseminated Pneumonia without mechanical causes.*—I believe that I do not go too far in saying that the greater portion of the cases regarded as chronic tuberculous affections belong to this disease, with these characteristic alterations.

The most frequent anatomical form is alveolar inflammation, alveolitis. In these cases are found foci, from yellow granulations of very small size, miliary like true tubercles up to larger infiltrations, lobular, more voluminous yet, and confluent. There are found, moreover, peribronchial foci, with very considerable proliferation of cellular connective tissue around a bronchus, which often encloses in its cavity a thick, yellowish, cellular mass, easily detached. Finally, there are formed, more or less, considerable interstitial foci, from the size of a pea up to that of a small almond, composed entirely of the budding out and multiplication of the cells of the connective tissue. To constitute out of these diverse localizations particular species, would be so much the more unreasonable, as they are found combined together in almost every manner; but the proliferation of connective tissue, playing here as important a part as that of the epithelial. I am unwilling to accept the term epithelial pneumonia employed by some authors. The expression involves truth, but too partial to permits its application to all these foci, cellular (*alveolaires*), peribronchial and interstitial. In order to avoid an exclusive interpretation, I should say that true tubercles may be the point of departure of these foci; but this is the exception, not the rule. It is much more frequent to find tubercular granulations, disseminated either around pneumonic foci, or in other parts of the lungs.

I believe it may be established as an invariable rule, that when the two orders of alterations are found together, the oldest and most advanced pneumonic foci have been the primitive affection, and the tuberculous granulations have

been developed there in a consecutive and secondary manner. Very often, also, disseminated chronic pneumonia exists without trace of tubercle.

When these disseminated chronic pneumonias are examined, either in the condition of yellow granulations, or as more extensive circumscribed infiltrations, the microscope gives no satisfactory result. The proliferation of connective tissue, both interstitial and peribronchial, exhibits not elements resembling in all respects those of true tubercle; but these are found, moreover, here and there, under the form of granulations, which would be supposed, at first sight, to be tuberculous, if they were not found involved in the midst of irritation of connective tissue of diffuse interstitial pneumonia. When these foci have for their point of origin the air-cells, groups of cells and the lobules, there are found, especially towards the centre, indistinct, shriveled cells, resembling very closely the elements of tubercle. It is true that in the peripheral layers there are observed cells of pus and epithelium—these last swollen and granular, as I have described them from my former observations, and as they are likewise often encumbered around true tubercular granulations, may be either gray or yellowish. Indeed, it is this fact which has induced me for a long time to suspect the difference between pneumonic foci and true tubercle. I must admit that formerly my investigations upon this subject did not take into consideration sufficiently the formation, the generation of these products. On the other hand, the methods of investigation were too imperfect at that time, and, moreover, I recognized, since 1842, vesicular pneumonia, having previously served in L'Hôpital des Enfants with Messrs. Legendre and Bailly, whose investigations into the subject are justly valued even to-day. It is true, that, like them, I, for a long time, recognized only the acute form of alveolitis. However, in 1851, I presented to the anatomical society the lungs of a dog, into whose jugular vein I had injected mercury, and in which I had been able to determine the development of purulent foci, at once vesicular and lobular.

Without regarding more antiquated opinions, Reinhardt, an equally good pathological anatomist and micrograph, had long since demonstrated that solid, disseminated foci of a tuberculous appearance in the lungs, were of an inflammatory character; still, he did not take sufficient account of true tubercle, whilst Virchow, making use of what was true in the investigations of Reinhardt, separated true tubercles from these disseminated pneumonias, which he designated as caseous or scrofulous. Other distinguished authors have employed themselves upon this subject in France, especially Villemin, Herard and Corme, etc. In Germany, L. Meyer and others; but no one has better described the formation of these inflammatory products of chronic pneumonia than Colberg,* who had admirable methods of investigation. Already, previous to the recent publication of his memoir, I had commenced, with Dr. Nyss, the chief of my laboratory, experiments upon the inoculation of tubercle and other morbid products, and we have together revised my old experiments upon artificial irritation of the respiratory passages. Moreover, after the manner of Colberg, we have injected the majority of the lungs which we wished to examine, and made use of all the modern appliances for microscopic preparations. We have preserved a sufficiently large number in our collection of pathological anatomy in our laboratory, to enable us to supply a demonstration. Indeed, in order to decide difficult and arduous questions, it is necessary to examine, in a fresh state, but also after having been hardened and submitted to different liquids, the thin, injected slices, in order to be able to discover and to distinguish that, which, whether of tubercle or inflammatory product, takes its origin from the capillaries, from the air-cells, from the small bronchi, from the interstitial tissue, etc.

But one should not be intimidated by the length and difficulty of these investigations. After having made them a certain number of times, it is possible to distinguish with the naked eye all the varieties of pulmonary alterations, which

* Deutches Archiv. fur Clinische Medicin. 1866. 2 Band. 4 a 5 Heft, p. 153.

we have already done, up to the present time, in the presence of pupils, whilst practicing autopsies.

The study of acute and subacute vesicular pneumonia, enables us to see the alveoli (air-cells), filled with muco-pus with epithelial and pus cells, more extensive purulent cavities, even to little foci of lobular hepatization, with a granular, yellowish section. In all these conditions, the hyperplastic product of the epithelium, whether alveolar (cellular), or especially bronchial, may become thickened, and solidify itself, so to speak. In disseminated chronic pneumonia, the smaller foci of a dead yellow, may vary from the size of a grain of dust to that of a hemp-seed, and larger, forming thus miliary granulations, but more dead, more yellow, more friable. These yellow granulations may group themselves together and form little infiltrations from the size of a lintel to that of a pea, or larger, yellow with a smooth and dry section, which, generally, from the very smallest, are scattered in a different manner, without clearly defined limits, in the surrounding pulmonary tissue. Already amongst these infiltrations, still small, it is not unusual to find in the centre, a little opening, corresponding to a lobular bronchus. In places, these masses exhibit a grayish color, probably from the remains of the capillaries which have disappeared, very generally the injections penetrated sufficiently far around these little inflammatory foci, without at all reaching into their interior.

In proportion as the granulations and lobular infiltrations are multiplied and become more confluent, infiltrations are developed, more extended, rounded, lobular, exhibiting a superficies like an oak leaf: a condition very well represented in the designs of Messrs. Herard and Cornel. It is not unusual to find around the miliary alveolar deposits, and between the confluent infiltrations a substance of a deep or reddish gray, partially transparent, which, in a more advanced state becomes firmer, more deep, and assumes a callous aspect of a slaty or blackish gray, in consequence of a considerable quantity of pigment. The infiltrated substance of a reddish gray originates often from immature hyperplasia of the interstitial

pulmonary connective issue. It may also exist under the form of little circumscribed masses; most frequently they are found combined with the yellowish foci of cellular (alveolar) origin. We are already familiar with inflammation around the bronchial tubes. More frequently still it is found around the larger bronchial tubes. These peribronchial foci have, at first, a grayish aspect, succulent, and are then composed of the cellular elements of the connective tissue in process of proliferation, and even in the midst of this diffuse inflammation are found some grayish granulations which resemble true tubercles. Later, these buddings of connective tissue become more yellow, drier; the bronchus, surrounded by this tissue, is ordinarily filled with the thickened product of its own secretion easily separable. Hence foci, miliary, lobular, confluent, extended, foci alveolar, peribronchial and interstitial, combined in every manner, but with a predominance of alveolar inflammation, constitute the anatomical elements of disseminated chronic pneumonia.

We have already seen in what manner the interstitial, peribronchial, inflammatory products are formed; as to those of the cells, they are certainly seen at an early period filled with very numerous epithelial cells in process of proliferation, as well as numerous cells of pus, either free or enclosed in the interior of the cells.

This multiplication of epithelia and formation of purulent elements, constitute the anatomical elements of alveolitis, without considering the hyperæmia of the capillary vessels around the alveoli; but the great difficulty is to determine their point of departure. Colberg, who has so well described their genesis, asserts that they originate from the continuous epithelium of the alveoli. It is known that among micrographs some recognize the existence of this alveolar epithelium, whilst others deny it. I have endeavored in vain to detect it in the adult man, even in preparations injected and dried, and in fine sections in various directions. I have seen there only intercapillary cells, such as Villemin and others describe. Now, these cells exist in too small numbers to explain those

so considerable cellular masses. I should, therefore, be much more disposed to believe, as in lobular pneumonia, in the hyperplasia of the epithelium of the ultimate bronchial terminations, budding out, multiplying themselves towards the alveoli, and terminating by filling them. Nevertheless, the question is still undecided, and very difficult to resolve. These epithelial elements form not only islets of alveolar infiltration, but also yellow, miliary granulations. These cells speedily undergo a profound alteration by granular or granulo-fatty infiltration, which render their appearance more opaque, then their interstitial serum is quickly absorbed; which, then, gives to the section an aspect dry, and of a dead yellow (caseous of authors). The capillaries not penetrating them, it is easy to understand the retrograde changes, cellular death, the "necrocythosis" of the inflammatory elements.

The debris of the capillaries form pigmentary granulations and stripes, grayish or darker, are abundant around the foci. Once the shells of the shrivelled alveoli becoming granular the resemblance to yellow tubercle is great, whilst their irregular diffusion in the pulmonary tissue, and their mode of formation render them easily distinguishable from true tubercle. Moreover, alveolitis involves as well the interstitial and peribronchial cellular tissue, whilst, on the other hand, inflammation of the connective tissue is combined with that of the alveolæ. It is not right, therefore, to give to chronic disseminated pneumonia the name of epithelial, a term proposed by several authors, but which would be too exclusive. When the inflammatory foci exist in good numbers, with a good state of the general health, they may gradually disappear completely, or diminish in volume, forming yellowish masses resembling glaziers' putty, or constituting little callous indurations of the cellular tissue, in which a species of stony mortar remains as a residue of the alveolar foci. These diverse conditions are combined in every mode, and are found by preference at the summit of one or both lungs, frequently even with a retraction of a cicatricial appearance on the surface. Sometimes, also, there are found in their neighborhood thick-

ened branchlets, obliterated or filled with the concrete product of their secretion.

It is not unfrequent that epithelial or purulent hyperplasia, exhausts itself speedily in the alveoli; and then it is the connective elements of the neighborhood which furnish the ulterior purulent elements.

The considerable masses of cellular elements described, excite in their turn an irritative process in their neighborhood. All these products tend to disintegration; a species of molecular necrosis progresses step by step, and it is thus that ulcerations are formed, at first small, then more and more voluminous, sometimes confluent. Ulcers known under the name of pulmonary caverns (*vomicæ*), surrounded often by more recent foci, which, in their turn, may undergo the same alteration. These irregular cavities tend to invest themselves with a membrane, which, when it covers them completely, may isolate them, and contribute gradually to their cicatrization; but most frequently the contents of the cavity are muco-purulent, and enclose the detritus of all these tissues in process of decomposition, mingled sometimes with the mycelia of fungi. The branches which open into these caverns are ordinarily ulcerated, and, as it were, cut perpendicularly at their opening, whilst the bronchial dilatations, equally frequent in the summit of lungs attacked by chronic pneumonia, are distinguished by the continuity of the mucous membrane of the branches into the whole of the dilated cavity. It is not unfrequent to see in these cavities larger blood-vessels which traverse them, and whose rupture produced the cavernous hæmorrhage, sometimes speedily fatal. The walls enclose also numerous capillaries, and their hair-like appearance is especially manifest when their cavities are examined with the lens under water. In fortunate cases, the inflammation of the connective tissue forms around the pulmonary ulcer a thick, callous substance, which, by becoming more and more dense, may induce from without inward the retraction and final cicatrization from the cavity. All these ulcers, from the very smallest, may, when they are situated

svperficially, open into the pleura, a perforation known under the title pneumo-thorax, and in rare cases with external perforation through the thoracic walls with pleuro-pulmonary fistula.

(*To be continued.*)

RETROVERSION OF THE PREGNANT WOMB.

BY F. R. MERGLER, M.D., WHEELING, COOK COUNTY, ILL.

PROF. ALLEN,—Having read with interest the paper of our medical brother, Dr. Bogue, published in the *Chicago Medical Journal* for July 15th, concerning that alarming accident of a pregnant woman, termed "*Retroversio Uteri*, I take the liberty to present you for your readers some lines on the same malady, together with a few cases, showing that this displacement can be successfully combated if we try to replace the womb *per rectum* with four fingers, instead of manipulating *per vaginam*, and that *abortus is avoided* in this manner. Lately the *colpeurynter* has been used for replacement of the womb. If we succeed by it, very well; but, if this elegant windbag should fail, too, it may be good to have another resource, which, in my experience, knoweth no failure.

In the year 1850, I had to meet my first case of *retroversio uteri* in a woman gone about three months. The principal trouble for which she applied, was an alarming *ischuria*. After due examination, *per vaginam*, I soon learned the real cause of her complaint, emptied the bladder by aid of the catheter, and then proceeded to restore the displaced uterus, manipulating (according to the teachings of books and professors) within the vaginal canal. But, as often as I pressed my finger against the posterior wall of the vagina, and upward against the impacted uterus, I failed constantly in every effort. Discouraged, I caused counsel to be procured, and although the venerable consiliarus did his best, no replacement was

effected. He had been manipulating in the same manner as I did—*per vaginam*. A few days afterwards, as could be expected, *abortus took place*.

Shortly after this sad disappointment I happened to see Dr. F. Kiwisch von Rotterhaus' recent publication on female diseases. Naturally, with the highest interest and curiosity, I studied his chapter on "*Retroversio Uteri Gravidi*." As soon as I had learned his advice for this accident, I felt at first not a little sorry, because I was now convinced that the above narrated unhappy success in my first case of *retroversio* would not have occurred, if I had sooner been acquainted with the method of Kiwisch. But I could not do any better than to press firmly into my memory his mode of operation, determined to try its merits as soon as occasion was given. I am unable to say whether Kiwisch is the real inventor of this *modus operandi*, but I had never before read any similar advice. It is chiefly this:

1. Empty the bladder with a *male* (not female) catheter. The cervix uteri in this accident being displaced forwards and upwards, presses firmly against the os pubis, and compresses, therefore, the neck of the bladder so strongly, that a real occlusion of it is effected. Hence, a well bent male catheter is more apt to enter the bladder by creeping around the *symphysis osseum pubis* upwards and forwards. A silver catheter may be preferable to an elastic one, and an index finger introduced into the vagina during the introduction of the catheter, should guard the blunt point of the catheter, and help to lead it around the symphysis, otherwise perforation of the neck of the bladder might be effected.

Having first emptied the over-extended bladder, you have removed one obstacle to the return of the womb to its normal place.

II. The next obstacle against the return of the womb in its place is that osseous projection from the sacral bone, known as the *promontorium pelvis*. The body of the womb, having been, by some mechanical cause, bent and forced back and downwards into the hollow of the sacrum, is held there fast

and prevented from re-ascension to its former erect position by the promontory. To overcome this difficulty, manipulation within the vagina is many times insufficient. We are better able to lift the uterus out of its malposition, *if we succeed in bringing the operating fingers between the uterus and sacrum.* Therefore, let the patient take a position on her knees, bending the head and upper part of the body down as far as possible. Lubricate your operating hand very well, and insert the first two fingers of it into the rectum of the patient. You will now detect through the *anterior* wall of the rectum, a roundish, elastic body, projecting below the promontory into the sacral excavation. If your fingers are long enough, you may press them instantly against the uterine body. But you will seldom be able with one or two fingers to complete the operation. You must, therefore, cautiously introduce the other two fingers also, the thumb remaining outside. This dilatation of the sphincter ani with four fingers is the only painful act of the operation, and a somewhat rude proceeding. But is is pretty well practicable, and secures the success.

As soon as you have inserted your hand into the rectum, you should give to it such a turn, that its back looks towards the sacrum. Now, you may commence to press with the tips of your fingers gently against the womb. From one to three forward pushings with your fingers will lift the womb out of its sacral bed, and will induce it to glide readily along the lower side of the promontory forward and return (at most with a kind of joyous jump) back into its former erect position. A digital examination *per vaginam*, will instantly satisfy you that the uterus is now well located again, and the troubles ended.

This is a condensed delineation of the mode of replacement of the retroverted uterus, after Kiwisch, as I have afterwards practiced, and in *none* of the cases where I tried it, was I disappointed any more.

I will therefore, now, to illustrate the result of this mode of operation, report a few cases of *retroversio uteri* which I have

met during my professional life, and which are, as I believe, highly encouraging.

Case I. (1858.) Mrs. V. of Lac Furic, Illinois; wife of a farmer; aged about forty years; of a very lax and feeble constitution; mother already of six children; pregnant again since three months. Sent for me, asking relief from a very troublesome ischuria. Examination proved very soon a case of retroversio of the pregnant uterus, existing about two days. Proceeded to make the replacement after Kiwisch's method, the first time operating *per rectum with the hand.* Operation succeeded satisfactorily.

Case II. Only fourteen days after this reposition of the womb, the same lady returned to my office, complaining as before. Made the replacement again in same manner successfully. No abortus afterwards occurred. No other troubles throughout the whole pregnancy were felt. At the termination of it, she was delivered of a full grown child by the aid of the forceps, which I had to use on account of absence of expulsory contraction of the womb. The child was dead. Mother recovered well, and gave birth afterwards to three other children. Had never again in any of her further pregnancies to complain of *retroversio.* But the two last of her children had each one to be taken from her with forceps. Mrs. V. having had her share now, since then she has enjoyed relatively good health up to the present time.

Case III. (1866.) Mrs. H., of Long Grove, Ill.; wife of a farm laborer; aged about thirty years; mother of several children; generally healthy and hard-working; pregnant for four months. She informed me that just four weeks before this she was attacked severely with ischuria. Her impotence to void her urine, turned after a few days of great suffering, to the other extreme. The urine flowing again could not be retained at all any more. Constantly, a blood-colored urine was dropping away from her, and wherever she was going, sitting or standing, the floor below was soiled with the water. This state of things was yet present, and I was not a little surprised that things had so long their way without medical interference.

The external examination of the poor sufferer's abdomen showed the bladder extended to a tremendous volume, so that it could be easily mistaken for the womb itself in highest pregnancy.

The examination *per vaginam* elucidated unmistakably another case of *retroversio uteri gravidi.* After the necessary explanations, I introduced first the male catheter, and abstracted not less than nearly three-quarters of a pail full of bloody urine of the most penetrant bad odor. After this, the abdomen came instantly down to a shape more adequate to a four months pregnancy. Then I made the reposition of the womb *per anum* with the hand (four fingers), as before described, and had the satisfaction to restore the poor woman in a short time to a normal state again. Re-examination *per vaginam* proved it instantly.

Mrs. H. from this time had no untoward symptom any further. In due and regular time (after five months more), she was delivered of a full grown child, which is alive and well.

Case IV. (1868). The same lady called at my office again about the 4th of July. Was anew pregnant since three months, and for the last two days troubled as once before with inability to void her urine. Examination proved that we had to combat another retroversion of the womb. This I did successfully as in the cases before, and Mrs. H. expects again a safe delivery when her time will come. At least, no abortus has yet occurred.

This is my experience in the line of *retroversio uteri* during a practice of twenty-eight years. If any one of our brethren, in case of emergency, after other methods and even the colpeurynter have failed—would try the above described method of *replacement per anum with the hand*, I feel confident that he will not, as I did, *experience disappointment.* The dilatation of the sphincter ani with the four fingers may be with many a serious objection, but having been compelled, as I was once, to resort to it, it will be found not half so dangerous as expected. Notwithstanding, I wish heartily that this rough proceeding may be spared to our patients, if there is any possibility.

IMPACTED FRACTURE OF THE NECK OF THE FEMUR SIMULATING ILIAC DISLOCATION.

BY JOHN E. OWENS, M.D., SURGEON TO ST. LUKE'S HOSPITAL, CHICAGO.

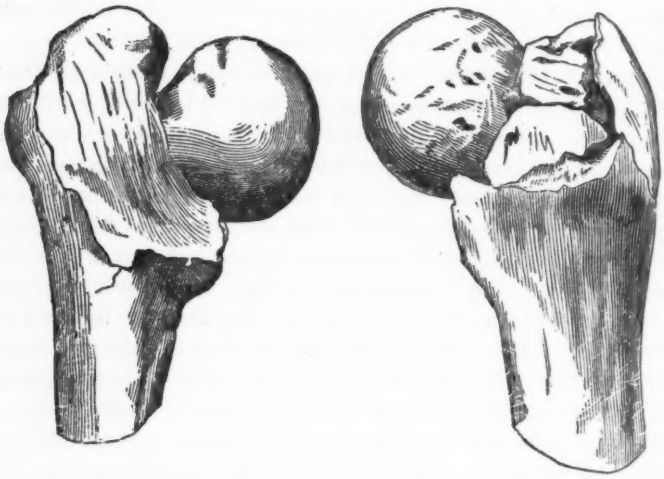
W. B., aged 73, a stone-cutter, was admitted to St. Luke's Hospital, December 24th, 1865. About a week before his admission, the patient, upon entering his room, and, in the dark, groping about for the matches, fell over a chair. Some pain was felt in the hip-joint at the time, but almost immediately he got up, struck a light, and went to bed. The patient did not feel that he was at all injured; but, in consequence of his becoming more and more debilitated, his friends brought him to the hospital. Upon admission he was pale, thin and haggard, appetite almost entirely gone, pulse feeble and rather frequent, and extremities cold. He said that he had no pain—indeed, no uneasiness, but that he only felt weak, and that his appetite was gone. The history of the case was given intelligently, yet his own statement gave no clue to the existence of any affection other than debility. The nurse, however, informed me that his thigh was bruised. The leg was found in the following condition: there was considerable ecchymosis about the groin, and extending over two-thirds of the thigh of the affected side; a comparative fullness of the region of the ant. sup. spine, and the trochanter major; the knee a little above, and somewhat in advance of the sound one; the foot inverted; the great toe directed towards the opposite tarsus; the thigh slightly bent upon the pelvis, and the leg upon the thigh; the limb from one-half to two inches shorter than the sound one. Neither whilst recumbent, nor whilst we held him in an upright position, was crepitation elicited; the limb could be moved pretty freely in all directions, yet movement caused considerable pain about the joint; the arc described by the great trochanter, upon rotating the

affected limb, seemed about equal to that of the other side; extension applied at the knee did not lengthen the limb; the foot was able to be everted, but, when left to itself, returned to the position already described. We diagnosed impacted fracture of the neck of the femur. The leg was placed in a comfortable position upon pillows. In a few days an intractable diarrhœa supervened, and the patient, refusing medicines, nourishment and stimulus, died January 12th, 1866.

It will be readily seen, from the history of this case, what must have been the difficulties encountered in making out the diagnosis. After listening to the lectures upon the various injuries and affections of the hip-joints, or after studying the able articles upon such affections, in some of our works upon surgery, the younger surgeon is pretty apt to come to the conclusion that the differential diagnosis, at least between a fracture and a dislocation, is rather an easy matter. Cases now and then occur, however, which throw many difficulties in the way of diagnosis. The subject of this paper serves to illustrate some of these difficulties. For instance, here is a case, the symptoms of which are almost entirely those of an iliac dislocation, viz.: the fullness about the hip, the position of the knee, the inverted foot; the great-toe pointing towards the opposite tarsus; the want of crepitation, and the non-restoration of the proper length of the limb by extension.

In making up the diagnosis, four facts are taken into consideration: the patient was an old man, the head of the bone was not felt on the dorsal surface of the ilium, as it can be in those subjects in iliac dislocation; the limb could be moved tolerably freely in all directions, and there was a want of crepitation. In old men—men over 65—owing to its comparative brittleness, the neck of the femur will commonly give way before a dislocation is produced; and, indeed, the forces that, in middle life, usually produce dislocations, in old age produce fractures. In an iliac dislocation, the foot, as mentioned above, is firmly fixed in a constrained manner; but there is no reason, except from the consensual avoidance of pain, why this should be the reason in an impacted fracture. Indeed,

in this case, the free motion of the afflicted limb, and the want of crepitation, owing to the firm manner in which the fragments are locked together, were the diagnostic symptoms—and that, too, in spite of the knee and foot assuming a position directly the reverse of that usually attributed to this species of fracture.



We were not able to have an autopsy in the hospital, but one night whilst at work in the dissecting room of one of the colleges, this old man's body was brought in by the resurrectionist. The bone was found in the condition in which the figure represents it, viz.: there are six pieces; the fracture extends through the trochanters; the neck is firmly impacted amongst the surrounding fragments; the upper end of the shaft and one of the larger pieces are somewhat excavated, forming a socket for the broken end of the neck; there was no evidence that the reparative process had commenced amongst the fragments; the pieces were held in excellent position, and any successful efforts to have restored the limb to its normal length and position, would have placed the parts in a position less capable of bony union, than the one in which the autopsy revealed them. It is well known that bony

union has taken place in this variety of fracture, and that, too, in patients older than this one. Occurring usually in old and feeble persons, it is better not to disturb the relative position of the impacted fragments; for a shortened, but firm limb is much better than a fracture. In the examination of these cases, the movements of the leg must be conducted with gentleness, lest the neck be displaced from its impacted position. Extension, especially, must be used very cautiously, and rather with a view to discover if the limb is extensible, than to efface any shortening that may exist. Placing the patient upon a firm and comfortable mattress, and the limb on a double-inclined plane (one of pillows is a good one), and the administration of tonics and the most concentrated nourishment, will give us the best results.

CORRESPONDENCE.

CASE OF PUERPERAL CONVULSIONS—HOMŒOPATHY *vs.* COMMON-SENSE.

Mr. Editor,—Sure that too much light from experience can not be thrown upon so frightful an aberration of the nervous system, as is known under the name of "Puerperal Convulsions," and aware that in the light of such cases, the relative merit of the various "pathies" and common-sense medicine becomes especially evident, I am induced to send to the Journal the following notes.

Mrs. B., a stout young Irish woman, of very full habit, was delivered of her first child on the morning of August 5th, at 4 o'clock. The attending doctor advertises as follows: "*Obstetrics—Specialty.* My patients have always the happy result of short and easy labor, instead of dread and suffering. Mild, pleasant (in homœopathic form) remedies, free. Low fees."

One hour after her delivery, she was seized with a severe

convulsion. These continued, with more or less frequency, until 3 P. M. of the same day. A hygieno-homœopath had been called in consultation. At my visit at 3 P. M., she was being convulsed every fifteen to twenty minutes. No urine had been passed through the day, nor for some hours before her delivery; feet and ankles, and, indeed, her whole person, were œdematous. Her convulsions were very strong, and strangulation was imminent from mucus collecting in the air passages. I found the usual two little cups of water +?, and a little one side one sugar pellet that was being carried off by two voracious flies.

I immediately ordered three drachms of *Bromide of Potassium*, *Morphine*, *Chloroform*, and a lancet. I drew off two ounces of fair colored urine; bled her to three pints; gave in four hours two drachms of the *Bromide*, and kept her under the influence of *Chloroform* for three hours and a half; convulsions were not repeated. This, followed by a little diuretic and aperient, and a comfortable night, found her the next morning completely convalescent.

CONTRAST.

HOMŒOPATHIC SERIES.	COMMON-SENSE SERIES.
Two little solutions of ? One sugar pellet, and two flies carrying it off. Convulsions increasing in force and frequency. Death imminent.	Three pints of blood; two drachms *Bromide of Potassium;* three ounces of Squibb's *Chloroform.* Convulsions ceased. Convalescence commenced.

H. O. HITCHCOCK, M.D.

KALAMAZOO, *August 8th*, 1868.

A CASE OF MONSTROSITY.

NEW MAYSVILLE, *June 25th*, 1868.

PROF. ALLEN—DEAR SIR: Allow me to refer to you a case of monstrosity which fell into my hands not long ago. April 26, 1868, I was summoned to attend Mrs. L., aged 36 years, in her ninth confinement—eight months advanced. She was seized at 7 A.M. with violent pains, which were followed by

the escape of the liquor amnii—nearly half a gallon, according to her statement, came away. The pains ceased to recur until afternoon. I proceeded to make an examination: found the os uteri dilated about the size of a quarter of a dollar, and the membranes pouching through, and could barely touch what I took to be an elbow. I was unable to make out a positive diagnosis, as it would recede from my finger on the slightest touch. After the elapse of several hours, the os was sufficiently dilated so that I ruptured the membrane, and near a quart escaped. I introduced my hand and found that I had a knee, instead of an elbow presented. I succeeded in bringing down the feet, and congratulated myself with the thought that delivery would soon take place; but pain after pain caused but little or no progress. I gave her *Ergot.* The contractions became very active. I made gentle but firm traction, but ineffectually. Her powers began to fail. I thought I was justifiable in a stronger effort, which was made, and I soon discovered I was making some progress. In examining the breach, I could feel no trace of any genital organs, but distinctly felt a tumor on the left hip nearly as large as a pullet's egg, soft and compressible. After delivering the breach, I felt something in or protruding through the vagina, which I first thought to be the placenta, but another firm contraction, and I felt quite a different substance. On examination the first proved to be the liver of the child, the remainder was the abdominal viscera, and that the child was neither male nor female, there being no trace of the genitals or rectum. The abdomen was contracted, and the viscera *developed on the outside*, surrounded by the membrane, which I had previously ruptured. The opening was not partially, but perfectly closed. They were attached by a small place (one-half inch in diameter). Just below the umbilicus and the umbilical cord, or what served its purpose, was a small, flat substance, about one-fourth the normal size, and two and one-third or three inches long, and seemed to unite or be continuous with the membranes covering the intestines. There was some little deformity of the lower extremities, but the

head, thorax, and upper extremities were well developed. I think the shortness of the cord was the cause of the protracted labor, which gave way at the last effort of traction. After delivery, the most frightful hæmorrhage ensued. I introduced my hand and delivered the placenta, and had no farther trouble. Yours, truly,

R. W. Long, M.D.

To the Editor of the Chicago Medical Journal:

Dear Sir: Was called, May 16th, to see a son of Mr. Mc., aged 16 years. Found the patient suffering from what is called colic. I learned from him that he had for a considerable time been suffering from an attack of pain about the umbilicus which came on in the afternoon. He had been visited by Dr. G. of this place previous to my seeing him. He had given him *Podophyllin* as a cathartic, which acted very severely, producing watery discharges. Upon examination I found the abdomen very much swollen, the tumor occupying the centre of the abdomen, and extending into the right iliac region. There was no pain nor tenderness upon pressure; tongue coated white; pulse 120; surface dry and hot. Prescribed *Hydrargyri, Chloridi. Mit*, gr. 60; *Dover Powder*, gr. 36. Divide into six powders, one to be given every four hours. *Potassa Acetas*, ℥ ss; *Aqua*, ℥ vii. Dose teaspoonful every two hours. May 16th, but little alteration; bowels had moved three or four times, pulse the same. Continued same treatment, with a diminution of the *Hydrarg.* May 17th, tongue beginning to clean off; pulse 110; bowels had moved twice, during which he had passed twenty worms; surface slightly moist, but as yet there is no diminution of the tumor, neither does he manifest any pain or soreness. Ordered *Ferri et Quiniæ Citratis* in doses of six gr. every four hours. May 18th, called in Dr. S. in consultation. Continued same treatment in addition to *Potass. Iodidi.* Continued this treatment for several days with no perceivable change or

diminution of the tumor. But the patient gradually gained strength, and during the time walked about the yard. And from this time he began to emaciate gradually, and June 16th was worse again. Tumor was quite as prominent as before, but has become general over the whole abdomen, with considerable pain; pulse 120 per minute with slight vomiting; bowels had moved in the morning, and urine had passed off freely. Prescribed *Opiates*, with *Syrupus Ferri Iodidi.* At this point a pustular eruption made its appearance upon the face, and gradually extended over the whole body. Two days later his bowels began to move off freely, accompanied with much pain. The treatment here consisted of *Astringents*, with *Tonics.* From this time he began to emaciate, and expired on the 15th of July.

A few days previous to his death the tumor became much softer, simulating a dropsical effusion. After the tumor began to soften he passed urine very freely, almost constantly. A *post mortem* examination was requested, but the friends would not consent.

Now to review the case briefly:—1st. The tumor appeared in the form of a pyramid, the umbilicus occupying the top and centre of the pyramid. 2nd. The tumor was as hard as adamant. 3rd. A few days previous to the patient's death the tumor became soft, (and I will state here that no pus was passed at all, neither was there any fluctuation to be felt in the tumor at any time.) His appetite remained good throughout his sickness. He was a mere skeleton at his death. 4th. What was the difficulty?

The case has been reported substantially as it occurred, and if deemed worthy of publication, we should be pleased to have the views of some of the numerous readers of the JOURNAL.

B. F. LIGHTFOOT, M.D.

MURRAYVILLE, ILL., *July 21st*, 1868.

PHILADELPHIA CORRESPONDENCE.

PHILADELPHIA, *August* 3, 1868.

MEDICAL EDUCATION.—It is remarkable that in the discussions which have been maintained in the meetings of the American Medical Association on the above topic, men who have been supposed to be among the "*soundest* of the *sound*," should advocate the resolution which was offered two years ago relative to this matter. That the standard of medical education and profession should be high; that men who are to take lives in their hands should be amply qualified thus to do, no sensible man doubts or disputes; but that any man should be allowed to run on in any path he desires while *preparing* for his lectures; that he should be sent to our colleges unable to tell where Peru or Greenland are; unable, scarcely, to write his name properly, or certainly to spell with correctness. In short, devoid of a common school education; and in this state of mind thrust upon our colleges, and as he approaches the Dean is told, "Now, sir, you are here, and here you must stay four years. You must learn geology, botany, astronomy and philosophy, in addition to your regular studies of the profession." How absurd does this seem to us! Not that we have a lower opinion of medicine than we ought, or than others. Not because we think the physician goes well enough prepared to go from his college, and simply because it is a piece of injustice to the faculty and to the student. That many an one goes away from our colleges ill prepared for his duties, we grant; but is this the way to remedy it? We think not. On the contrary, it is just the way to check the prosperity of our colleges, and to dishearten many an one who, if properly instructed, might adorn his profession. Such a plan existing, and what would be the result? A man coming from some country village to Jefferson College, or Rush College, or elsewhere. He has been under his *preceptor* (?) a

certain length of time; knows what the spinal column is composed of; knows, perhaps, the description of the *sphenoid* bone *by heart;* can tell you where the *glutæus muscles*, or the *sphincter ani* are, but when told that he has to learn all about geology, etc., etc., and that he must stay "three years at the least," he holds up his hands in holy horror, and leaves for the plough again.

Now, what is the way to bring up the standard of medical education? How shall the colleges send forth men better prepared for their duties? Not in this way. Let the standard be raised in the *preceptor's* office. Here is the place, and no where else. Let him there go through the proper preparatory studies, and, if necessary, undergo an examination prior to entering the college. By such means medical gentlemen will go out into the world better fitted, and the colleges will be prosperous in the extreme. If such men as the "gentleman from Cincinnati," or the "tall man with gray hair," from Philadelphia would advance such an idea as this in regard to medical education, and not such Utopian ones as they did, they could do far more good to the world, and reflect far more credit on themselves, with the hope of *sometime* seeing their scheme successful. Yours,

E. R. H.

BOOK NOTICES.

A Theoretical and Practical Treatise on Midwifery, including the Diseases of Pregnancy and Parturition. By P. Cazeaux, Member of the Imperial Academy of Medicine, etc., etc., Paris. Revised and annotated by S. Tarnier, Adjunct Professor in the Faculty of Medicine, Hospital Surgeon, etc., etc., Paris. Fifth American, from the seventh French edition, by Wm. R. Bullock, M.D. One hundred and seventy Illustrations. Philadelphia: Lindsay & Blakiston. 1868. Pp. xxxi. 1124. Chicago: S. C. Griggs & Co. Cloth, $6.50; leather, $7.50.

There are few books on this subject more widely known or more highly appreciated than this. It is unnecessary to enlarge upon the merits of the original editions by the celebrated author, whose comparatively recent demise the whole professional world laments. It is or should be in the library of every student and practitioner. The present edition has undergone at the hands of M. Tarnier many and important alterations and additions. Cazeaux's text is in large type—Tarnier's portion being indicated by a smaller letter. A single glance at the book will show that the latter's office has been no sinecure. Aside from additions, the plan of the whole has been so greatly modified so as to make it essentially a new work. Full credit is awarded to contemporaries, especially where new theories or procedures are proposed.

On the whole, this may be well considered as the most complete and advanced record of Obstetrical science and Gynæcology that is in the possession of the profession.

It is needless to say that the eminent American publishers have done their work excellently well. We trust they may be rewarded by the abundant sale this production so preëminently deserves.

THE ANATOMY AND HISTOLOGY OF THE HUMAN EYE. By A. METZ, M.D., Professor of Opthalmology in Charity Hospital Medical College, Cleveland, Ohio. Philadelphia: Published at the Office of the *Philadelphia Medical and Surgical Reporter*. 8vo. pp. xvi, 184. Price, $2.50, postage paid.

This is an exhaustive treatise on the subject, and yet both compact and clear. The older and more voluminous treatises on the Anatomy and Histology of the Eye, whilst wearisome to read, do not furnish a tithe of the matter this work contains. From the array of authorities (about forty) credited in the primary pages, we are promised the very latest and best information, and this promise perusal of the book shows to be religiously fulfilled. There are seventy-five neat and accurate illustrations, with lucid descriptions. The whole is issued in creditable style by the publishers. We congratulate the

author on the successful accomplishment of the effort announced in his preface, and the publisher on its elegant "make up."

KLINIK DER OHRENKRANKHEITEN. Ein Handbuch für Studirende und Aerzte, von Dr. S. Moos, Praktischer Arzt und docent an der Universität ein Heidelberg. Mit 26 in den Text Gedruckten Holzschnitten; Wien, 1866, Wilhelm Braumüller.

Those of our readers who are familiar with the German language, will find this an excellent work of reference in the case of Diseases of the Ear.

PROGRESSIVE LOCOMOTOR ATAXIA. Being extracts from two papers on this topic, read before the Wood County Medical Association, Parkersburg, W. Virginia. By WALTER COLES, M.D., Professor of Diseases of Women and Children in Medical College of Virginia.

The author in this tractate brings together the prominent characteristics of this much to be dreaded disease, and brings its pathological history up to the present time.

CHICAGO: Past, Present and Future. By JOHN S. WRIGHT. Chicago: Western News Co. 8vo. pp. 404.

Those interested (and who is not?) in this Metropolis of the North-west, will find herein recorded the reasons why its growth has taken place, and why it must continue. The author writes *con amore*, and with the confidence of one who can truthfully say *quorum pars fui*, having been one of the earliest settlers. It is illustrated by maps, views of public buildings, etc., etc. The task of compiling the array of facts and figures given must have been a very onerous one, and we have every reason to believe has been executed with perfect integrity and fidelity. Unbelievers in the continued prosperity and stability of this city, have only carefully to read and ponder this book to become convinced that Chicago will, at no distant day, rank as the second city on the continent. Buy it and read.

EDITORIAL.

Please Notice.

Correspondents and visitors will please notice that the heterogeneous jumble of names, known as the *Chicago Directory* for 1868–9, locates the Editor's office and residence at *Rush Medical College.* He has the honor of an official connection with that College, but his office is at 71 South Dearborn street, and his residence at 503 Michigan Avenue.

The oppositions of previous years made the several Directories tolerably reliable, but the *union* of the present year has proved any thing but strength, except to the olfactories. It will be difficult for visitors to find their friends or acquaintance, save by tracing them out in the Directories of previous years.

The Reform School.

We have only space remaining in the present number to call attention to the fact that, according to the circulars of the "*one school only in the United States,*" and its exposition in the columns of a contemporary, the pretended increase of requirements previous to graduation is a pretense and nothing more. The sliding scale adopted, as it is said, *temporarily*, can easily be seen to be a mere farce. The *status in quo* remains as before the Quixotic crusade of the "Phantom in Black."

The Nashville Imbroglio.

In a late number we referred to the decision of Chancellor Shackleford with reference to Professors Eve, Jennings and Jones. It seems that the case afterwards went into chancery, and Judge Milligan issued a writ of *supersedeas*, etc., etc., the effect of which is to oust these gentlemen and sustain the new appointees. The writ issued, and Professors E., J. and J. are solemnly commanded to desist from all efforts to enforce Chan-

cellor Shackleford's interlocutory order or decree, etc., etc. Whereupon Prof. Bowling issues a pronunciamento assuring the profession that everything is lovely, the new Faculty *en rapport* with right and justice, and harmony prevails. All of which we shall steadfastly believe until the next order from the courts. Meanwhile we can not conceive why the Nashville school is anxious to get rid of gentlemen so widely and favorably known as are Prof. Eve and his *confreres*. Do they drink too much? Or what is it? We await the issue of another circular to relieve our anxiety.

The Medical and Surgical History of the Rebellion,

Being compiled in the Surgeon General's office, seems likely to be delayed in publication through the failure of sufficient appropriation therefor. Sixty thousand dollars were appropriated by the act of June 8th, 1868, for the publication of this history and the medical statistics of the Provost Marshal General's bureau—thirty thousand each. The superior cost of the first causing some trenching on the resources of the second, a special resolution was passed July 25th, ordering the balance of the appropriation to be devoted exclusively to the Provost Marshal's figures. This action is exceedingly to be regretted, for the profession were looking to the completion of the former work with very great expectations of benefit. It is to be hoped that some means will be afforded, during the coming session, to expedite this most important work.

Cook County Hospital, City of Chicago.

Winter Term of Clinical Instruction, 1868–9.—The regular course of Clinical Instruction in this Institution will commence on Friday, Oct. 2d, 1868, and continue for *nine months*.

The prosperity of this great public hospital, liberally supplied with the most adequate means for clinical and practical instruction, affords an extensive field for the study of every form of medical, surgical, and special disease.

During the year ending July 31st, 1868, over eleven hundred patients were treated in this hospital. Upwards of one hundred important surgical operations were performed.

In the lying-in department, there were ninety-eight births.

The large number of autopsies,—usually made in the presence of the class,—together with the pathological museum, give an excellent opportunity for the study of morbid anatomy.

The Dispensary, for out-patients, is organized so as to classify diseases, that every applicant shall receive the most thorough attention. This alone furnishes a large number of interesting cases.

Lectures will be delivered as follows: Surgical Clinics, with operations, and Medical Clinics, with examinations at the bedside, on Tuesdays and Fridays; Eye and Ear Clinics, with operations, and Clinic on Diseases of Women, on Saturdays, commencing invariably at half past one, and continuing two hours.

It is the purpose of the medical staff to use and develop the immense resources of the hospital for the promotion of medical education, and to add whatever is possible to the means and facilities for medical study attainable in Chicago. The object for which they will earnestly labor being an elevated standard of professional knowledge among the students, and such junior practitioners as may seek our city for this purpose.

Fee for admission to the Hospital, $5. Graduate practitioners free.

Lectures on the Eye and Ear.

In addition to the course of lectures and operations on the Eye and Ear, embraced in the regular term of clinical instruction at the County Hospital, Dr. Hildreth will also deliver a *special course* on these organs.

The theory and uses of the ophthalmoscope, the analysis and treatment of the "accommodation," astigmatism, and other optical and mechanical defects of the eye will be dwelt upon.

The methods of exploring the ear will be fully demonstrated.

The number of interesting cases in the Eye and Ear Wards of the Hospital, ensures abundant opportunity for becoming familiar with ophthalmic and aural disease.

The Charitable Eye and Ear Clinic—a Free Dispensary, established by prominent citizens of Chicago, is likewise accessible to students.

The hospital ticket admits, without further charge, to all of the above.

O'Reilly Prize.

Dr. John O'Reilly, of New York, having offered, through the New York Academy of Medicine, a Prize of Six Hundred Dollars for an Essay on the Physiology and Pathology of the Sympathetic or Ganglionic Nervous System, the Committee of Award appointed by the Council of the Academy, have adopted, with the concurrence of the Council, the following Regulations:

I.—The competing Essays shall be sent in to the Chairman of the Committe, Prof. J. C. Dalton, No. 101 East Twenty-third street, New York, on or before the First day of March, 1869.

II.—Each Essay shall be marked with some distinguishing device or motto, and accompanied by a sealed envelope bearing the same device or motto, and containing the name and address of the writer.

III.—The Essay selected by the Committee shall be transmitted by them, together with its accompanying envelope, to the Council of the New York Academy of Medicine, under whose direction the envelope shall be opened and the name of the writer announced at the first meeting of the Academy, in May, 1869.

IV.—This prize is open for universal competition.

V.—The Committee have a right to reject whatever does not come up to a proper standard of merit.

Alfred C. Post, M.D., *Pres't of the Academy, on behalf of the Board.*

Committee of Awards.—J. C. DALTON, M.D., Professor of Physiology in the College of Physicians and Surgeons, New York; A. FLINT, Jr., M.D., Professor of Physiology in the Bellevue Hospital Medical College, New York; ALFRED L. LOOMIS, M.D., Professor of the Institutes and Practice of Medicine in the University Medical College, New York.

☞ Medical journals are particularly requested to copy.

NEW YORK, *December*, 1867.

FOREIGN NOTES AND EXCERPTA.

M. A. TRIPIER, in a paper read before the Academy of Sciences, Paris, (June 15), suggests the use of anæsthetic inhalation for the relief of every form of hepatic colic. He takes the ground that it is upon the activity of the reflex function that the expulsion of calculi depends. He further asserts that experiments, in which section of the spinal cord has been practiced, the pathological observations of cerebral paralysis of Marshall Hall, and the results of chloroformic anæthesia in obstetrical practice, demonstrate that the most certain means of increasing the intensity of reflex phenomena is to isolate the organs which constitute its seat, from the controlling influence of the brain. In the case under consideration, the intention is to induce temporary cerebral paralysis, under the influence of which the intensity of reflex phenomena may be increased, and thus the expulsion of the calculi effected.

THE exhaustive discussion upon tuberculosis, which has occupied the Academy during so many months, still drags its slow length along. It will undoubtedly develop all that is known upon the subject up to the present date in France.

In view of the marked increase in the prevalence of pulmonary tuberculization in Paris, the medical society of the hospitals of that city has appointed a special commission (*Commission de Phthisiologie*) to pursue the study of this specialty, and has nominated MM. Hérard, president, Chauffard, Moutard-Martin, Villemin, and Potain, secretary. This commission appeals to all physicians to communicate to it all the facts bearing upon the etiology of tuberculosis.

DR. LAWSON reports to the *London Lancet* a case of eschar, produced upon the breast of a young woman from the effects of pulverized ether.

MESSRS. Protheroe Smith and Heywood Smith, report to the same journal favorably upon the tetrachloride of carbon as an anæsthetic agent. As the result of fifty-one experiments, they recommend its use to relieve pain in Cephalagia, Dysmennorrhœa, Toothache, and that in particular it diminishes pain while it does not diminish the intensity of the contractions of the uterus.

MR. BIRKETT (Guy's Hospital), reports the complete reunion of a severed metacarpal bone, by means of wire suture, applied through perforations made in the bone. The same surgeon reports also a case of fractured lower jaw treated successfully in the same way. Also, several cases of ununited fractures of bones, by the introduction of ivory pegs between the fragments.

M. FOLKER reports to the *Gazette Médicale* a case of poisoning by swallowing three grains of strychnine, which was successfully treated by inhalations of chloroform. This is the second case reported.

TRICHINIASIS AND THE TRICHINA is again occupying the attention of the Academy of Sciences (Paris). M. Colin has just presented the results of his investigations into this subject in its relations to Zoology, Hygiene and Pathology. The Hygienic relations of this parasite are the most immediately interesting, and in these nothing specially new is elicited.

We learn from Suez that this year the return of the pilgrims from Mecca has been effected in the midst of the most favorable sanitary conditions. The measures adopted by the international conference at Constantinople have operated in the most satisfactory manner.

Seven thousand two hundred and twenty-six pilgrims arrived at Suez, by sea and land. They have been kept in quarantine, and out of the entire number, but twenty-five have died at the lazaretto—twelve of dysentery, eight of pulmonary disease, and five of old age.

BIOLOGICAL SOCIETY — PARIS. — 1. *Physiology:* Changes in the pressure of the air in the chest during the two phases of the respiratory act. By M. P. Best.

During inspiration, a true diminution of pressure exists in the lung, and during expiration a compression of the air. In other words, the calibre of the trachea is not sufficiently large for the demands of the respiratory movements. This is shown by diagrams taken under the following conditions: An animal is placed under a bell glass with tubular attachment closed below, whose capacity is from four to five times the volume of the animal. By means of the tube a communication is established with the drum of Masey's polygraph, the registering cylinder being set in operation, the lever is seen to move in a certain direction at each inspiration of the animal, and then to go in the opposite direction at each expiration succeeding.

The movement following the inspiration indicates an augmentation in the volume of the air contained in the bell. Now this can take place only in consequence of an energetic demand which the animal makes, a demand which is not sufficiently satisfied by the exterior air; so that the air of the lung is dilated again in volume for the system. The contrary takes place from the moment of expiration.

Here is certainly the most simple and the most convenient mode of studying the rythm, and the different conditions of the respiratory movements in animals. It is remarkable that the different animals do not give identical results. Thus a dog, a cat, a rabbit, a duck, all of nearly the same volume, having been placed successively under the same bell, the most emphatic line was that of the duck; then came the dog and the cat, which resembled each other nearly, and after a long interval the rabbit, which made only a great number of minute, rapid oscillations. The same difference was presented by a guinea pig compared with a pigeon. A turtle effects decided movement; an adder and a frog, none at all.

After an interval of some minutes the curve is seen to direct itself in its totality, in a manner which seems to indicate an absorption of the medium: this is due to the insufficient production of carbonic acid, compared to the oxygen supplied. When the animal is excited, the curve is elevated in a manner to indicate a great demand for air, intrathoracic

dilatation. This takes place as well from one effort of forcible inspiration, as by a series of profitable (beneficiares) inspirations, that is to say, followed by incomplete expirations. Then comes a series of movements in which expiration gains upon inspiration, which restores the original equilibrium.

It would be interesting to know the value of this diminution of pressure in relation to the quantity of air absorbed at each inspiration, but this experiment could hardly be made upon man.

Position in the Reduction of Inguinal Hernia—*By Dr. Joseph B. Bond, Yarmouth, Nova Scotia.*—Several years ago, I had a case in which the patient could not reduce an inguinal hernia while lying in bed, either on his side or on his back, but as soon as he stood on his feet there was not the least difficulty. If, on removing his truss before going to bed, he neglected to apply his hand to the part and allow the rupture to protrude, he had always to get upon his feet before he could reduce it. Soon after this I was called to a case of strangulated inguinal hernia. After making every effort in the usual way to reduce it, I directed the patient to stand up; I placed myself (also standing) behind him, and encircled his body with both my arms, grasped the tumor with both hands, and effected in a few minutes what I had failed to accomplish in as many hours. Since then I have had many cases of inguinal hernia in my own practice, and several where I have been called in consultation, and have never failed to effect a reduction in a few minutes in the way I have described. I have never seen this means tried in the Hospital in Philadelphia nor in the London Hospital, although in both these institutions I have repeatedly seen all efforts fail to reduce an inguinal hernia without an operation. Nor have I ever seen it recommended in any surgical work.

My object in sending you this communication is to ask my medical brethren of the metropolis to give the erect posture in the reduction of inguinal hernia a fair trial, and to publish the results. In femoral hernia the erect posture has never succeeded in my hands—in three cases I have been obliged to use the knife—in inguinal, never. I will not attempt to account for the use of the erect posture in the reduction of inguinal hernia, nor for its failure in femoral. It may be thought that the erect posture favors reduction by causing syncope, but in only two cases do I remember that a feeling of faintness was complained of. In the last case (only a few days ago) the patient, an old man, fainted and fell as soon as the gurgling began to be felt, and I finished the reduction whilst he was prostrate.—*Medical Times and Gazette.*

Peroxide of Hydrogen as a Remedy in Diabetes—*By Dr. John Day, Geelong, Australia.*—[The patient was 36 years of age, and was progressively getting worse, passing as much as five quarts of highly saccharine urine during each night.]

While pondering over the hopeless condition of my patient, it occurred to me that if I could oxidize the sugar that had been taken up in the general circulation, it would be an approach towards the natural mode of elimination by the lungs. With this object in view, I gave half-drachm doses of ethereal solution of peroxide of hydrogen mixed in an ounce of distilled water, three times a day.

To enable me fully to explain the theory on which I base my treatment, would occupy far more of your valuable space than I could justly claim. Schonbein believes that peroxide of hydrogen is H O antozone, and that the blood-corpuscles possess, in a very high degree, the property of decomposing it, and of transforming its antozone into ozone, without, in themselves,

undergoing any very rapid change; and he further believes that ozone is the only condition in which oxygen possesses any active combining properties. Assuming these views to be correct, we should possess in ethereal solution of peroxide of hydrogen, which would be rapidly absorbed, a ready means of destroying, by oxidation, the sugar in the blood, and of also maintaining the animal heat, which, in the treatment of diabetes, is an important consideration. I may observe, that what is sold by Mr. Robbins as Dr. Richardson's ozonic ether is, in reality, a solution of peroxide of hydrogen in ether. This may be readily proved by adding a few drops of it to a weak solution of chromic acid: a beautiful blue colour will be the result, caused by the formation of perchromic acid. This preparation is in every respect similar to that which I have been using, and in the therapeutical effects of which I have now had some years' experience.

I commenced the use of this new remedy on August the 10th, and, as the following extracts from my case-book will show, with most gratifying results to the patient:

Aug. 12th. From 10 P.M. to 10 A.M., passed about five pints of urine. Previously for many months, the quantity of urine passed during the night averaged five quarts.

13th. Quantity of urine passed during the night, rather less than three pints and a half. Thirst not so urgent.

14th. Quantity of urine passed during the night, two pints and a half. Urine strongly acid; specific gravity 1046. Thirst much less urgent.

16th. Quantity of urine passed during the night, rather less than forty ounces. The patient very much improved in every respect. I give her own words:—"I have no thirst now; no more than I had in olden times. I feel that I am cured if it will only last."—*Lancet.*

Carbolic Acid a Cure for Toothache.—Among the many virtues of Carbolic acid is that of giving relief from the pain of toothache. I have tried it in a great many cases, and with invariable success. To one drachm of collodium flexile (B. P. 1867) add two drachms of Calvert's carbolic acid, full strength. A gelatinous mass is precipitated. A small portion of this precipitate inserted into the cavity of an aching tooth gives immediate relief. It may be kept in the cavity by means of a bit of lint dipped in the collodium.—*Lancet, Feb.* 22, 1868, *p.* 275.

To the Editor Chicago Medical Journal— *Dear Sir:* Will you kindly insert the following notice or its equivalent in your paper, and thus aid a worthy cause?

The New York Medical College for Women will begin their Sixth Annual Term of twenty weeks, at their new College in Twelfth Street, corner of Second Avenue, the first Monday in November. For announcements, giving full particulars, address, with stamps, the Dean, Mrs. C. S. Lozier, M.D., or the Secretary, Mrs. C. F. Wells, Box 730, N. Y.

Comments are unnecessary.—Ed.